THE RIGHT MOMENT FOR STEM CELL TRANSPLANTATION IN ONE CASE OF REFRACTORY HIGH RISK AML M4

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We present the case of GC 44 years old man with AML M4 with MDS, dg in 20.02.2012 with 39 % blasts in bone marrow aspirat and MDS, poor - risk cytogenetics and who has a matched related donor: his sister 100 % compatible. In 24.02 - 02.03.2012 he has received standard - dose ARA C plus Etoposide induction: ICE protocol (ARA C + Idarubicine + Etoposide) with residual blasts 13% and MDS after completion of induction. We send him to Fundeni Transplant Department and we agree to make the salvage therapy: S-HAM protocol for tumor reduction before transplantation. In 04.04 - 12.04.2012 he has received high dose ARA - C with Mitoxantrone with good initial response and 3 % blasts in bone marrow aspirat, with normal peripheral blood counts in 27.04.2012. We send him again to Fundeni Transplant Department, but after 2 weeks the procentage of medulary blast is increasing (8%) and he has received another cycle of chemotherapy, this time FLAG - ETO in 16 - 21.05.2012, complicated with pulmonary aspergilosis, treated with VFend 400 mg/d. The procentage of blast is 9-10 % in 12.06.2012 and is incresing at 13 - 15 % in 19.06.2012. He was sent in Colentina Hospital with refractory AML: 12 % blast in peripheral blood and 20% in bone marrow aspirat in 02.07.2012, sever pancitopenia and febril aspergilosis under Vfend, but with no other failure: renal, cardiac, leaver; ECOG scor 0/I.

Our patient has chest CT (made in 21.06.2012) that shows aspects of pulmonary aspergilosis in both lungs with cavitary lesion in upper superior right lobe (19 mm) and microlesion in the left one (invasive pulmonary aspergilosis) but now is under therapeutical control with VFend 400 mg/d for almost 1 month. His pancytopenia is most probably a result of the disease: 20 % blasts in bone marrow aspirat and 12 % in peripheral blood and myelodisplastics elements, because the FLAG-ETO portocol was finished in 21.05.2012., with no response.

In 13.07.2012 we repeated chest CT that shows aspects of pulmonary aspergilosis in both lungs with cavitary lesion in upper superior right lobe (10 mm) and microlesion in the left one (invasive pulmonary aspergilosis) un improvement under treatment with Voriconazol.

We also did a bone marrow aspiration in 18.07.2012 that shows over 80% blast and myelodisplastic elements. We apllied minidoses of CYTARABINUM 100 mg/d s.c. 10 days with MITHOXANTRONE 10 mg/d in day 1, 3 and 5, and ETOPOSIDE 200 mg/d in day 8, 9, 10. The protocol was finished on 25.07.2012. After 18 days the patient was still pancitopenic and bone marrow aspiration showed 30 - 35 % blasts and myelodisplastics elements. The bone pain is not controlled by the treatment (Tramadol + Perfalgan + Fentanyl). ECOG score is now 3.

Is there a right time when this patient could do stem cell transplantation? Is there a solution for such a disperate case?